

Bladder cancer

Quality standard

Published: 17 December 2015

www.nice.org.uk/guidance/qs106

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This standard is based on NG2.

This standard should be read in conjunction with QS55, QS15, QS91 and QS124.

Introduction

This quality standard covers diagnosis and management of bladder cancer in adults (18 years and older) referred from primary care. It includes suspected, newly diagnosed and recurrent bladder cancers (urothelial carcinoma, adenocarcinoma, squamous cell carcinoma or small-cell carcinoma) and urethral cancers. For more information see the [bladder cancer topic overview](#).

Why this quality standard is needed

Bladder cancer is defined by the development of a tumour in the lining of the bladder. In the case of non-muscle-invasive bladder cancer, cancerous cells are contained inside the lining of the bladder. Muscle-invasive bladder cancer occurs if cancerous cells spread to the surrounding muscle.

The main risk factor for bladder cancer is increasing age, but smoking and exposure to some industrial chemicals also increase risk.

Bladder cancer is usually identified on the basis of visible blood in the urine or blood found by urine testing. It often presents for the first time as an emergency admission, which is frequently associated with a poor prognosis.

According to Cancer Research UK's [Bladder cancer incidence statistics](#), in 2012 bladder cancer was the seventh most common cancer in the UK, with just over 10,700 cases diagnosed that year. In 2012 it was also the seventh most common cause of cancer death in the UK, accounting for approximately 5200 deaths in that year. Bladder cancer is 3–4 times more common in men than in women, and most cases occur in people aged over 60. The involvement of the urogenital tract and the nature of the treatments give bladder cancer a strong psychological impact, in addition to the physical impact of the disease and its treatments, which is often profound.

Most bladder cancers (75–80%) do not involve the muscle wall and are usually treated with telescopic removal of the cancer (transurethral resection of bladder tumour [TURBT]). This may be followed by instilling chemotherapy or vaccine-based therapy into the bladder, with prolonged telescopic checking of the bladder (cystoscopy) as follow-up. Some people with non-muscle-invasive bladder cancer who are at higher risk of poor prognosis are treated with

major surgery to remove the bladder (cystectomy).

Adults with cancer in or through the bladder muscle wall may be treated with intent to cure using chemotherapy, cystectomy or radiotherapy, and those who have cancer too advanced to cure may have palliative radiotherapy and chemotherapy.

The quality standard is expected to contribute to improvements in the following outcomes:

- experience of care: hospital and outpatient services
- experience of carers: palliative care
- quality of life for adults with bladder cancer
- cancer survival rates
- premature mortality.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2015–16](#)
- [Public Health Outcomes Framework 2013–16](#).

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [NHS Outcomes Framework 2015–16](#)

Domain	Overarching indicators and improvement areas
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<p>1 Preventing people from dying prematurely</p>	<p>Overarching indicators</p> <p>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare:</p> <p>i Adults</p> <p>1b Life expectancy at 75</p> <p>i Males ii Females</p> <p>Improvement areas</p> <p>Reducing premature mortality from the major causes of death</p> <p>1.4 Under 75 mortality rate from cancer* (PHOF 4.5)</p> <p>i One- and ii Five-year survival from all cancers</p> <p>v One- and vi Five-year survival from cancers diagnosed at stage 1&2** (PHOF 2.19)</p>
<p>4 Ensuring that people have a positive experience of care</p>	<p>Overarching indicator</p> <p>4b Patient experience of hospital care</p> <p>4d <i>Patient experience characterised as poor or worse</i></p> <p>ii. <i>Hospital care</i></p> <p>Improvement areas</p> <p>Improving people's experience of outpatient care</p> <p>4.1 Patient experience of outpatient services</p> <p>Improving hospitals' responsiveness to personal needs</p> <p>4.2 Responsiveness to inpatients' personal needs</p> <p>Improving people's experience of accident and emergency services</p> <p>4.3 Patient experience of A&E services</p> <p>Improving the experience of care for people at the end of their lives</p> <p>4.6 Bereaved carers' views on the quality of care in the last 3 months of life</p>
<p>Alignment across the health and social care system</p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p>	

Table 2 Public health outcomes framework for England, 2013–16

Domain	Objectives and indicators
2 Health improvement	<p>Objective</p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p>Indicators</p> <p>2.19 Cancer diagnosed at stage 1 and 2** (NHSOF 1.4)</p>
4 Healthcare public health and preventing premature mortality	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities</p> <p>Indicators</p> <p>4.3 Mortality rate from causes considered preventable** (NHSOF 1a)</p> <p>4.5 Under 75 mortality rate from cancer* (NHSOF 1.4)</p>
<p>Alignment across the health and social care system</p> <p>* Indicator shared with the NHS Outcomes Framework</p> <p>** Complementary indicators in the NHS Outcomes Framework</p>	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to bladder cancer.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and are supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for bladder cancer specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole bladder cancer care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults with bladder cancer.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality bladder cancer service are listed in [related quality standards](#).

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating adults with bladder cancer should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting adults with bladder cancer. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. Adults who are having transurethral resection of bladder tumour (TURBT) have detrusor muscle obtained during the procedure.

Statement 2. Adults with suspected bladder cancer are offered a single dose of intravesical mitomycin C, given at the same time as the first transurethral resection of bladder tumour (TURBT).

Statement 3. Adults with bladder cancer have access to a designated clinical nurse specialist.

Statement 4. Adults with newly diagnosed non-muscle-invasive bladder cancer have a risk classification of their cancer completed.

Statement 5. Adults with high-risk non-muscle-invasive bladder cancer discuss intravesical Bacille Calmette-Guérin (BCG) and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist.

Statement 6. Adults with muscle-invasive urothelial bladder cancer discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist.

Statement 7. Adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial transurethral resection of bladder tumour (TURBT) are discharged to primary care.

Quality statement 1: Obtaining detrusor muscle during transurethral resection of bladder tumour

Quality statement

Adults who are having transurethral resection of bladder tumour (TURBT) have detrusor muscle obtained during the procedure.

Rationale

Obtaining detrusor muscle during TURBT is important for assessing the stage and type of bladder cancer, which can help to identify the most effective treatment.

Quality measures

Structure

Evidence of local arrangements to ensure that adults having TURBT have detrusor muscle obtained during the procedure.

Data source: Local data collection.

Process

Proportion of TURBT procedures during which detrusor muscle was obtained.

Numerator – the number in the denominator in which detrusor muscle was taken at the time of performing the TURBT.

Denominator – the number of TURBT procedures performed.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care services) ensure that systems are in place for adults who are having TURBT to have detrusor muscle obtained during the procedure.

Healthcare professionals ensure that adults who are having TURBT have detrusor muscle obtained during the procedure.

Commissioners (clinical commissioning groups) ensure that they commission services that obtain detrusor muscle during TURBT procedures.

What the quality statement means for patients and carers

Adults who are having an operation to take tissue samples to check for bladder cancer (called transurethral resection of bladder tumour, or TURBT for short) have samples taken that include tissue from the muscle wall of their bladder. If cancer is found in their bladder, the type of treatment will depend on whether or not the cancer has grown into the muscle wall.

Source guidance

- [Bladder cancer](#) (2015) NICE guideline NG2, recommendation 1.2.4

Quality statement 2: Chemotherapy during transurethral resection of bladder tumour

Quality statement

Adults with suspected bladder cancer are offered a single dose of intravesical mitomycin C, given at the same time as the first transurethral resection of bladder tumour (TURBT).

Rationale

A single dose of intravesical mitomycin C given at the same time as the first TURBT has been found to reduce recurrence rates. Giving mitomycin C at the same time as the first TURBT is more convenient for the person having the TURBT and results in cost savings.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with suspected bladder cancer who are having a first TURBT are offered a single dose of intravesical mitomycin C, given at the same time as the TURBT.

Data source: Local data collection.

Process

Proportion of first TURBT procedures in which adults with suspected bladder cancer are given a single dose of intravesical mitomycin C.

Numerator – the number in the denominator in which a single dose of intravesical mitomycin C is given.

Denominator – the number of first TURBTs performed for adults with suspected bladder cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for example secondary care services) ensure that systems are in place for adults having a first TURBT for suspected bladder cancer to be offered a single dose of intravesical mitomycin C, given at the same time as the TURBT.

Healthcare professionals offer adults having a first TURBT for suspected bladder cancer a single dose of intravesical mitomycin C, given at the same time as the TURBT.

Commissioners (NHS England) ensure that they commission services that offer adults having a first TURBT for suspected bladder cancer a single dose of intravesical mitomycin C, given at the same time as the TURBT.

What the quality statement means for patients and carers

Adults who are having a first operation to take tissue samples to check for bladder cancer (called transurethral resection of bladder tumour, or TURBT for short) are offered a single dose of an anticancer drug called mitomycin C, which is given when they have the operation. If cancer is found in their bladder, mitomycin C can reduce the chance of it coming back again in the future.

Source guidance

- [Bladder cancer](#) (2015) NICE guideline NG2, recommendation 1.2.7

Quality statement 3: Access to a clinical nurse specialist

Quality statement

Adults with bladder cancer have access to a designated clinical nurse specialist.

Rationale

Adults with bladder cancer who are supported by a clinical nurse specialist have a better experience of bladder cancer services than those who are not. The clinical nurse specialist can be involved in discussing treatment options and act as the person's key worker to address their information and care needs, including psychosocial support and referral to palliative care if needed. They can also discuss the effects of treatment on the person's body image and sexual health, and help them find relevant information.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that designated clinical nurse specialists are accessible to adults with bladder cancer.

Data source: Local data collection.

Process

Proportion of adults with bladder cancer who have a designated clinical nurse specialist.

Numerator – the number in the denominator who have a designated clinical nurse specialist.

Denominator – the number of adults with bladder cancer in secondary care.

Data source: Local data collection.

Outcome

Satisfaction with support received from a clinical nurse specialist, reported by adults with bladder cancer.

Data source: Local data collection. The [National cancer patient experience survey](#) collects data on support from a clinical nurse specialist for adults with urological cancers.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care services) ensure that systems are in place for adults with bladder cancer to have access to a designated clinical nurse specialist.

Healthcare professionals offer adults with bladder cancer access to a designated clinical nurse specialist.

Commissioners (clinical commissioning groups) ensure that they commission services that offer adults with bladder cancer access to a designated clinical nurse specialist.

What the quality statement means for patients and carers

Adults with bladder cancer are offered support from a clinical nurse specialist who has experience in caring for people with bladder cancer. The clinical nurse specialist can provide information about bladder cancer and the treatment options, and help them find information and other support they might need.

Source guidance

- [Bladder cancer](#) (2015) NICE guideline NG2, recommendations 1.1.2 and 1.1.3

Quality statement 4: Risk classification

Quality statement

Adults with newly diagnosed non-muscle-invasive bladder cancer have a risk classification of their cancer completed.

Rationale

Risk classification of non-muscle-invasive bladder cancer is used in multidisciplinary team discussions and in discussions with the person to help consider prognosis and decide treatment options.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with newly diagnosed non-muscle-invasive bladder cancer have a risk classification of their cancer completed.

Data source: Local data collection.

Process

Proportion of adults with newly diagnosed non-muscle-invasive bladder cancer who have a risk classification of their cancer completed.

Numerator – the number in the denominator who have a risk classification of their cancer completed.

Denominator – the number of adults with a new diagnosis of non-muscle-invasive bladder cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care services) ensure that systems are in place for adults with newly

diagnosed non-muscle-invasive bladder cancer to have a risk classification completed.

Healthcare professionals complete a risk classification for adults with newly diagnosed non-muscle-invasive bladder cancer.

Commissioners (clinical commissioning groups) ensure that they commission services that complete a risk classification for adults with newly diagnosed non-muscle-invasive bladder cancer.

What the quality statement means for patients, service users and carers

Adults with bladder cancer that has not grown into the muscle wall of the bladder have information about the likely future risk from their cancer, including the risk of it growing into the muscle wall, written in their notes when the cancer is first diagnosed. This information helps them and their doctors to decide the best treatment options.

Source guidance

- [Bladder cancer](#) (2015) NICE guideline NG2, recommendation 1.3.1

Definitions of terms used in this quality statement

Risk classification of non-muscle-invasive bladder cancer

Low risk

Urothelial cancer with any of:

- solitary pTaG1 with a diameter of less than 3 cm
- solitary pTaG2 (low grade) with a diameter of less than 3 cm
- any papillary urothelial neoplasm of low malignant potential.

Intermediate risk

Urothelial cancer that is not low risk or high risk, including:

- solitary pTaG1 with a diameter of more than 3 cm
- multifocal pTaG1

- solitary pTaG2 (low grade) with a diameter of more than 3 cm
- multifocal pTaG2 (low grade)
- pTaG2 (high grade)
- any pTaG2 (grade not further specified)
- any low-risk non-muscle-invasive bladder cancer recurring within 12 months of last tumour occurrence.

High risk

Urothelial cancer with any of:

- pTaG3
- pT1G2
- pT1G3
- pTis (Cis).

[[Bladder cancer](#) (NICE guideline NG2) section 1.3]

Quality statement 5: Discussing treatment options for high-risk non-muscle-invasive bladder cancer

Quality statement

Adults with high-risk non-muscle-invasive bladder cancer discuss intravesical Bacille Calmette-Guérin (BCG) and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist.

Rationale

Discussing the benefits and risks of intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist helps adults to make an informed choice about which treatment would best suit them. It ensures that they are aware of the possible outcomes and implications of both treatments, including likely effects on their quality of life, body image, and sexual and urinary functions.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with high-risk non-muscle-invasive bladder cancer discuss intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist before a treatment option is agreed.

Data source: Local data collection.

Process

The proportion of adults with high-risk non-muscle-invasive bladder cancer who discuss intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist before agreeing a treatment option.

Numerator – the number in the denominator who have a discussion about intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist before agreeing a treatment option.

Denominator – the number of adults with newly diagnosed high-risk non-muscle-invasive bladder cancer.

Data source: Local data collection.

Outcome

Satisfaction with explanation of treatment options reported by adults with high-risk non-muscle-invasive bladder cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care services) ensure that systems are in place for adults with high-risk non-muscle-invasive bladder cancer to discuss intravesical BCG and radical cystectomy with a urologist who performs both treatments and a clinical nurse specialist before agreeing a treatment option.

Healthcare professionals (urologists who perform both intravesical BCG and radical cystectomy, and clinical nurse specialists) discuss both procedures with adults who have high-risk non-muscle-invasive bladder cancer before agreeing a treatment option.

Commissioners (clinical commissioning groups) ensure that they commission services in which a clinical nurse specialist and a urologist who performs both intravesical BCG and radical cystectomy discuss both of these procedures with adults who have high-risk non-muscle-invasive bladder before agreeing a treatment option.

What the quality statement means for patients and carers

Adults with bladder cancer that has not grown into the muscle wall of the bladder, but has a high risk of doing so, have a discussion with a clinical nurse specialist and a specialist bladder cancer doctor about having treatment either with a vaccine called BCG, which can stop the cancer growing, or by having their bladder removed in an operation called cystectomy. Knowing the benefits and risks of these treatment options, including the likely effects on their future quality of life, will help them to choose the option that is best for them.

Source guidance

- [Bladder cancer](#) (2015) NICE guideline NG2, recommendation 1.3.6

Definitions of terms used in this quality statement

Discussion

Discussion should include:

- the type, stage and grade of the cancer, the presence of carcinoma in situ, the presence of variant pathology, prostatic urethral or bladder neck status and the number of tumours
- risk of progression to muscle invasion, metastases and death
- risk of understaging
- benefits of both treatments, including survival rates and the likelihood of further treatment
- risks of both treatments
- factors that affect outcomes (for example, comorbidities and life expectancy)
- impact on quality of life, body image, and sexual and urinary functions.

[[Bladder cancer](#) (NICE guideline NG2) recommendation 1.3.6]

Equality and diversity considerations

Radical cystectomy may not be suitable for people who have problems with manual dexterity or cognitive function, or people who have visual impairment.

Quality statement 6: Discussing treatment options for muscle-invasive urothelial bladder cancer

Quality statement

Adults with muscle-invasive urothelial bladder cancer discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist.

Rationale

Discussing the benefits and risks of neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist helps adults to make an informed choice about the treatments that would best suit them. It ensures that they are aware of the possible outcomes and implications of the treatments, including likely effects on their quality of life, body image, and sexual and urinary functions.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with muscle-invasive urothelial bladder cancer discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist.

Data source: Local data collection.

Process

The proportion of adults with muscle-invasive urothelial bladder cancer who discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist before agreeing a treatment option.

Numerator – the number in the denominator who have a discussion about neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who

performs radical cystectomy, a clinical oncologist and a clinical nurse specialist before agreeing a treatment option.

Denominator – the number of adults with muscle-invasive urothelial bladder cancer.

Data source: Local data collection.

Outcome

Satisfaction with explanation of treatment options reported by adults with muscle-invasive urothelial bladder cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care services) ensure that systems are in place for adults with muscle-invasive urothelial bladder cancer to discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist before agreeing a treatment option.

Healthcare professionals (urologists who perform radical cystectomy, clinical oncologists and clinical nurse specialists) discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with adults who have muscle-invasive urothelial bladder cancer before agreeing a treatment option.

Commissioners (NHS England and clinical commissioning groups) ensure that they commission services in which a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy using a radiosensitiser with adults who have muscle-invasive urothelial bladder cancer before agreeing a treatment option.

What the quality statement means for patients, service users and carers

Adults with bladder cancer that has grown into the muscle wall of the bladder have a discussion with a clinical nurse specialist and specialist bladder cancer doctors about either having their bladder removed (cystectomy) or having radiotherapy (high-energy rays that destroy cancer cells).

They also discuss having chemotherapy (treatment with anticancer drugs) before having either of these treatments. Knowing the benefits and risks of these treatment options, including the likely effects on their future quality of life, will help them to choose the option that is best for them.

Source guidance

- [Bladder cancer](#) (2015) NICE guideline NG2, recommendations 1.5.2 and 1.5.3

Definitions of terms used in this quality statement

Discussion

Adults with newly diagnosed muscle-invasive urothelial bladder cancer for whom cisplatin-based chemotherapy is suitable should be offered neoadjuvant chemotherapy using a cisplatin combination regimen before radical cystectomy or radical radiotherapy. They should have an opportunity to discuss the risks and benefits with an oncologist who treats bladder cancer.

[[Bladder cancer](#) (NICE guideline NG2) recommendation 1.5.2]

Adults with muscle-invasive urothelial bladder cancer for whom radical therapy is suitable should be offered a choice of radical cystectomy or radiotherapy with a radiosensitiser, and have their choice of treatment based on a discussion with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist.

The discussion includes:

- the prognosis with or without treatment
- the limited evidence about whether surgery or radiotherapy with a radiosensitiser is the most effective cancer treatment
- the benefits and risks of surgery and radiotherapy with a radiosensitiser, including the impact on sexual and bowel functions and the risk of death as a result of the treatment.

[[Bladder cancer](#) (NICE guideline NG2) recommendation 1.5.3]

Equality and diversity considerations

Radical cystectomy may not be suitable for people who have problems with manual dexterity or cognitive function, or people who have visual impairment.

Quality statement 7: Discharge to primary care

Quality statement

Adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial transurethral resection of bladder tumour (TURBT) are discharged to primary care.

Rationale

Discharging adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months to primary care reduces the need for follow-up cystoscopies in secondary care. It is important that the discharge is discussed with the patient beforehand, and that written information about the patient's care is sent to the GP who will be taking over their care when they are discharged.

Quality measures

Structure

Evidence of local arrangements for adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial TURBT to be discharged to primary care.

Data source: Local data collection.

Process

Proportion of adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial TURBT who are discharged to primary care.

Numerator – the number in the denominator who are discharged to primary care.

Denominator – the number of adults who have had low-risk non-muscle-invasive bladder cancer who have no recurrence of the bladder cancer within 12 months of their initial TURBT.

Data source: Local data collection.

Outcome

Satisfaction with discharge to primary care reported by adults who have had low-risk non-muscle-invasive bladder cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care services) ensure that systems are in place for adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial TURBT to be discharged to primary care.

Healthcare professionals discharge to primary care adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial TURBT.

Commissioners (clinical commissioning groups) ensure that they commission services that discharge to primary care adults who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months of their initial TURBT. Commissioners work with providers in primary and secondary care to ensure that there is good communication between primary care, secondary care and the person who is being discharged.

What the quality statement means for patients and carers

Adults who have had bladder cancer removed in an operation called transurethral resection of bladder tumour, or TURBT for short, are discharged back to their GP after 1 year if there are no further signs of cancer, the cancer had not spread into the muscle wall of the bladder, and it was a type of cancer with a low risk of spreading or coming back in the future.

Source guidance

- [Bladder cancer](#) (2015) NICE guideline NG2, recommendation 1.4.5

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its [Indicators for Quality Improvement Programme](#). If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's [what makes up a NICE quality standard?](#) for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#), NICE's cancer service guidance on [improving outcomes in urological cancers](#) and the National Cancer Peer Review Programme's [Manual for cancer services: urology](#).

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between healthcare professionals and adults with bladder cancer is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with bladder cancer should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the [quality standards process guide](#).

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Bladder cancer](#) (2015) NICE guideline NG2

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- National Audit Office (2015) [Progress in improving cancer services and outcomes in England](#)
- UK National Screening Committee (UK NSC) (2015) [The UK NSC recommendation on bladder cancer screening in adults](#)
- Department of Health (2014) [National cancer patient experience survey](#)
- Department of Health (2014) [The national cancer strategy: 4th annual report](#)
- Map of Medicine (2014) [Bladder cancer – suspected](#) (A–Z; Athens login required)
- NHS England (2014) [Manual for cancer services – urology measures](#)
- National Cancer Intelligence Network (2013) [Bladder cancer incidence, mortality and survival rates in the United Kingdom](#)
- Department of Health (2012) [Improving older people's access to cancer treatment services](#)
- Department of Health (2011) [Commissioning cancer services](#)
- National Cancer Intelligence Network (2011) [Survival in patients treated by cystectomy for bladder cancer](#)
- Royal College of General Practitioners (2011) [National audit of cancer diagnosis in primary care](#)

Definitions and data sources for the quality measures

- Quality Health National cancer patient experience surveys

Related NICE quality standards

Published

- [Prostate cancer \(2015\) NICE quality standard 91](#)
- [Cancer services for children and young people \(2014\) NICE quality standard 55](#)
- [Patient experience in adult NHS services \(2012\) NICE quality standard 15](#)

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Referral for suspected cancer

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

Ms Deryn Bishop

Public Health Behaviour Change Specialist, Solihull Public Health Department

Jan Dawson

Registered Dietitian

Dr Matthew Fay

GP, Westcliffe Medical Practice, Shipley, West Yorkshire

Dr Malcolm Fisk

Senior Research Fellow at the Centre for Computing and Social Responsibility, De Montfort University, Leicester

Ms Margaret Goose

Lay member

Dr Madhavan Krishnaswamy

Consultant Clinical Oncologist, Southend University Hospital NHS Trust

Mrs Geeta Kumar

Clinical Director, Women's Services (East) Betsi Cadwaladr University Health Board

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Ms Ann Nevinson

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Professor of Social Policy Research, Social Policy Research Unit, University of York

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Independent Consultant, Gloucestershire County Council

Dr Karen Ritchie

Head of Knowledge and Information, Health Improvement Scotland

Dr Eve Scott

Head of Safety and Risk, The Christie NHS Foundation Trust, Manchester

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GP and Clinical Lead for Integrated Care, Harford Health Centre, Tower Hamlets Clinical Commissioning Group

Dr Jim Stephenson

Consultant Medical Microbiologist, Epsom and St Helier NHS Trust

Mr Darryl Thompson

Registered Nurse (Mental Health), South West Yorkshire Partnership NHS Foundation Trust

Mrs Julia Thompson

Health Improvement Principal, Sheffield City Council

The following specialist members joined the committee to develop this quality standard:

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Consultant and Honorary Senior Clinical Lecturer, Clinical Oncology, The Christie NHS Foundation Trust

Dr Ben Taylor

Consultant Radiologist, The Christie NHS Foundation Trust

Mrs Susan Thompson

Clinical Nurse Specialist

Mr William Turner

Consultant Urologist, Cambridge University Hospitals NHS Foundation Trust

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathway on [bladder cancer](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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ISBN: 978-1-4731-1613-9

Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based

guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Royal College of Pathologists](#)
- [Royal College of Nursing](#)